Defer/Freeze Distribution Request
Deferred Compensation Plan

Employer_____
To be completed by Employee

Group Number_____
To be completed by The Hartford

Print Name_____

Street_____

City/State/Zip_____

Social Security Number_____Phone Number_____

Signature_____Date_____

With respect to benefits payable to me from my deferred compensation account, I wish to defer receipt of any benefits until the following date, at which time I shall advise how the distribution is to be made.

I understand that this date may be changed ONE TIME ONLY (and only to a date later, but not earlier, in time) and will not be later than my reaching age 70 1/2.

_____
Indicate Month/Year

It is **very** important that you keep your address current. Please notify us of an address change. **619-624-2660 or 800-937-0862**